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on

MEDICARE IN RURAL AREAS

before the

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Chairman Talent, Congresswoman Velazquez, thank you for inviting me to be here today to discuss our efforts to support small businesses that provide health care in America's rural areas.

We understand that rural providers face unique challenges in serving the medical needs of their beneficiaries. Assuring and enhancing access to quality care for rural beneficiaries is a priority for us. About one in four Medicare beneficiaries live in rural America, and rural providers serve a critical role in areas where the next nearest provider may be hours away. Yet many of these rural providers have higher costs than their more urban counterparts and face difficulty maintaining enough patients to break even. Medicare has made exceptions and special arrangements to address the needs of rural America and strengthen providers in these areas. And we are committed to continuing to work with you to ensure that these unique needs are met.

We already have implemented a majority of provisions in the Balanced Budget Act of 1997 (BBA) that assist rural providers. We are eager to implement additional provisions targeted to the specific needs of rural providers that were included in the Balanced Budget Refinement Act (BBRA), which became law late last year. And we have taken a number of administrative actions to help providers adjust to changes in the BBA. These steps complement the legislative changes included in the BBRA and will help hospitals and other providers in meeting the needs of the patients they serve.

In addition, we have established a Rural Health Initiative within our agency to increase and coordinate attention to rural issues. This initiative includes senior staff and a specially designated rural point person in each of our 10 regional offices to respond to rural provider inquiries and concerns. And we have enhanced our relationship with our colleagues at the Small Business Administration (SBA) to ensure we consider the special needs of small health care providers in all of our programs, policies, and guidance.

We will continue to closely monitor how laws and regulations governing our programs affect rural beneficiaries and providers. And we want to work with Congress to make any additional adjustments that may be necessary to ensure that rural providers can continue to provide beneficiaries with access to the high quality care they deserve.

Balanced Budget Refinement Act

Working together, Congress and the Administration last year enacted the BBRA, which includes a

number of payment reforms and other changes to address some of the BBA's unintended consequences. A number of these refinements are particularly helpful to providers in America's rural areas and their patients.

The BBRA includes several provisions to assist Critical Access Hospitals, such as:

- applying the 96-hour length of stay limit on an average annual basis;
- permitting for-profit hospitals to qualify for Critical Access Hospital designation;
- removing constraints on length of stay in "swing beds" in hospitals with a total of 50 to 100 beds that serve both acute care and skilled nursing patients;
- allowing hospitals that have closed or downsized in the last 10 years to convert to Critical Access Hospital status;
- permitting Critical Access Hospitals to streamline their billing processes by combining physician and hospital charges; and,
- eliminating beneficiary coinsurance for clinical laboratory tests furnished by a Critical Access Hospital.

The BBRA also gives Sole Community Hospitals an enhanced annual update for FY 2001. For other rural hospitals, the BBRA holds them harmless for 4 years during the transition to the new prospective payment system for hospital outpatient care, and provides separate, budget-neutral payments for high-cost patients and certain drugs, devices, and biologicals for all hospitals, which will especially help hospitals that would otherwise have had to spread these costs across a small case load.

To help address the need for physicians in rural areas, the BBRA raises the caps by 30 percent on medical residents to strengthen hospital residency training programs in rural areas and encourages urban physician education programs to establish separate training programs in rural areas.

The BBRA extends the Medicare Dependent Hospital program for five years. This program assists small rural hospitals, which serve mostly Medicare patients. In general, Medicare patients make up at least 60 percent of a Dependent Hospital's inpatient days or discharges, have fewer than 100 beds, and do not serve as a Sole Community Hospital.

For skilled nursing facilities, the BBRA provides an immediate increase in payments to skilled nursing facilities that treat high-cost patients. It creates special payments to facilities that treat a high proportion of AIDS patients, and excludes certain expensive items and services from PPS consolidated billing requirements, such as ambulance services for dialysis, prostheses, and chemotherapy. Importantly, the BBRA provides an across-the-board increase of 4 percent for FY 2001 and FY 2002, and gives nursing homes options in how their rates are calculated. It places a two-year moratorium on the physical and occupational therapy caps included in the BBA, which appeared to be presenting particular problems for patients in these facilities.

For home health agencies, the BBRA delays a scheduled 15 percent pay cut until after the first year the new home health prospective payment system is in place. It also provides an immediate adjustment to the per beneficiary limits for certain agencies; gives assistance payments to help agencies cover the costs associated with the OASIS quality survey system; and excludes durable medical equipment from consolidated billing under the prospective payment system. Once the prospective payment system is implemented, payments will be tailored specifically to the condition and needs of the patients. In

addition, there will be no per visit or per beneficiary payment limits. A case-mix adjusted payment will be made for each 60-day episode of covered care, the limit on the number payment episodes will be removed, and agencies will receive extra payments to cover more costly cases.

Administrative Actions

Building on the changes included in the BBRA, we also have taken a number of administrative steps to assist rural providers in meeting the needs of the patients they serve. For example, we are implementing new policies to make it easier for rural hospitals, whose payments are now based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas. As a consequence of these policy changes, qualifying rural hospitals will receive higher reimbursement.

Similarly, we are helping rural hospitals adjust to the new outpatient prospective payment system by using the same wage index for determining a facility's outpatient payments rates that is used to calculate inpatient payment rates.

And we are postponing for a period of two years the expansion of the BBA's "transfer policy," which limits hospital payments when patients with certain diagnoses are discharged early from a hospital to a skilled nursing facility or post-acute care setting. As a result, the transfer payment limits will apply only to the current 10 specific conditions included under the BBA, and we are considering whether further postponement is warranted.

We also are taking administrative action to assist home health agencies. We are providing financial relief to agencies by extending the timeframe for agencies to repay overpayments resulting from the interim payment system from one year to three, with the first year interest-free. We are postponing the requirement for home health agencies to obtain surety bonds until October 1, 2000. And we have eliminated a "sequential billing" requirement that had been problematic for some agencies, including some in rural areas.

For skilled nursing facilities, we are using our administrative flexibility to refine, in a budget neutral way, the manner in which we classify medical conditions for purposes of payment in a way that more accurately reflects the full range of costs incurred on behalf of sicker patients. The refinements will likely increase payments for patients with complex medical conditions.

Rural Workgroup

We also are redoubling our efforts to more clearly understand and actively address the special circumstances of rural providers and beneficiaries. Last year, we launched a new Rural Health Initiative. We are meeting with rural providers, visiting rural facilities, reviewing the impact of our regulations on rural health care providers, and conducting more research on rural health care issues. We are participating in regularly scheduled meetings with the Health Resources and Services Administration's (HRSA) Office of Rural Health Policy to make sure that we stay abreast of emerging rural issues. And we are working directly with the National Rural Health Association to evaluate rural access to care and the impact of recent policy changes.

Our goal is to engage in more dialogue with rural providers and ensure that we are considering all possible ways of making sure rural beneficiaries get the care they need. We are looking at best practices and areas where research and demonstration projects are warranted. We want to hear from those who are

providing services to rural beneficiaries about what steps we can take to ensure they get the care they need.

We have put together a team for this rural initiative that includes senior staff in our Central and Regional Offices and dedicated personnel around the country. The work group is co-chaired by Linda Ruiz in our Seattle regional office and Tom Hoyer in our central office headquarters in Baltimore. Each of our ten regional offices now has a rural issues point person that you and your rural provider constituents can call directly to raise and discuss issues, ideas, and concerns. A list of these contacts and their respective States is attached. We are confident that this initiative will ensure that Medicare policies are attuned to the needs or rural health providers and beneficiaries.

Telemedicine

We are proceeding with projects to evaluate Medicare coverage for telemedicine. We recently completed a comprehensive, $2.3 million technology assessment of telemedicine, in conjunction with the Agency for Healthcare Research and Quality, under contract with the Oregon Health Sciences University. This study involved an assessment of the clinical and scientific literature dealing with the cost-effectiveness of telemedicine, specifically looking into the areas of store and forward, patient self-testing and monitoring, and potential telemedicine applications for non-surgical medical services. We will examine the results of this study to determine if there is a need to expand telemedicine beyond the current payment regulations.

We are also proceeding with demonstration projects to test expanded coverage for telemedicine to include teleconsultations in Medicare. On February 28, 2000, we awarded a $28 million cooperative agreement to Columbia University for the Informatics, Telemedicine, and Education Demonstration Project, as required by the BBA. This randomized, controlled study will explore how teleconsultations between physicians on the upper west side of Manhattan and in rural, upstate New York affect patient care and program costs. It focuses on intensive monitoring and education of Medicare beneficiaries with diabetes through the use of telemedicine devices, case managers, and the Internet. The demonstration is scheduled for completion on September 30, 2001, and an evaluation report is due 6 months after that completion date.

Coordination with the Small Business Administration

Most rural Medicare providers and suppliers are small businesses and we have been actively working to enhance our relationship with the SBA and ensure our policies are responsive to the needs of the small business community, including those located in rural areas.

For example, last year the SBA Office of Advocacy led training session for over 100 agency staff in our Baltimore headquarters to learn about the needs and concerns of small business providers and how best to address them when developing regulations and policies. We also regularly consult with the SBA when developing regulations that may have a particular impact on the small business community. This helps facilitate information sharing and ensures we are aware of any emerging small business issues or concerns.

Additionally, HCFA representatives participate in regional forums conducted by the SBA Ombudsman across the country. These forums allow staff in the field to learn firsthand about small business concerns and also give small health care providers the opportunity to share their needs, concerns, and ideas with us. And we conduct ongoing staff and contractor training, within our own Agency, to ensure that small business needs are addressed in all aspects of our programs and guidance.

Conclusion

We are all committed to ensuring rural beneficiaries' continued access to quality care, and we are all concerned about the disproportionate impact that policy changes can have on rural health care providers. The Balanced Budget Act, the Balanced Budget Refinement Act, and the administrative actions we have taken address these concerns with specific provisions targeted to assist rural providers. Our Rural Health Initiative and our consultation with the SBA will help us to take any additional steps that may be appropriate.

We are very grateful for this opportunity to discuss our efforts to help rural providers and beneficiaries, and to explore further actions we might take to address their concerns in a prompt and fiscally prudent manner. I thank you again for holding this hearing, and I am happy to answer your questions.

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